

HAMILTON URBAN CORE COMMUNITY HEALTH CENTRE  
**CHRONIC DISEASE PREVENTION AND MANAGEMENT APPROACH**

## INTRODUCTION

Over the past few years there has been greater attention given to the prevention and management of chronic disease, chronic illness and chronic conditions. It has been noted that Ontario faces increasing challenges in meeting the needs of people with chronic diseases given aging populations, poverty and other health or socio-economic conditions. This means that illnesses such as cardiovascular disease, diabetes, and arthritis, to mention a few, are becoming more prevalent and demands for care are increasing.

At Hamilton Urban Core chronic disease, chronic illness and/or chronic conditions including chronic social conditions are significant factors for the client population served and the manner of service delivery. This is particularly important as the Community Health Centre model causes us to address not only the physical aspects of an individual's health but to also equally address social, economic, spiritual factors described in whole as the social determinants of health. The overall goal is to enhance the client's health and quality of life.

The Hamilton Urban Core Chronic Disease Prevention and Management Approach is intended to serve as a guideline in providing comprehensive services to individuals living with chronic disease, chronic illness or chronic conditions and ensuring that the most appropriate providers are engaged in addressing "whole person" needs. The approach is also intended to complement existing best practices and recognize best practices or standards of good practice at Hamilton Urban Core that have developed or evolved in response to our particular client populations and their health and social service needs.

## WHAT IS CHRONIC DISEASE?

A chronic disease is a disease that is long-lasting or recurrent. The term chronic is used to describe the **course** of the disease, or its rate of onset and development. Chronic is also used to refer to a persistent and lasting medical condition but not always appear in the description such as the case with diabetes, cancer, cardiovascular diseases, osteoporosis or autoimmune diseases.

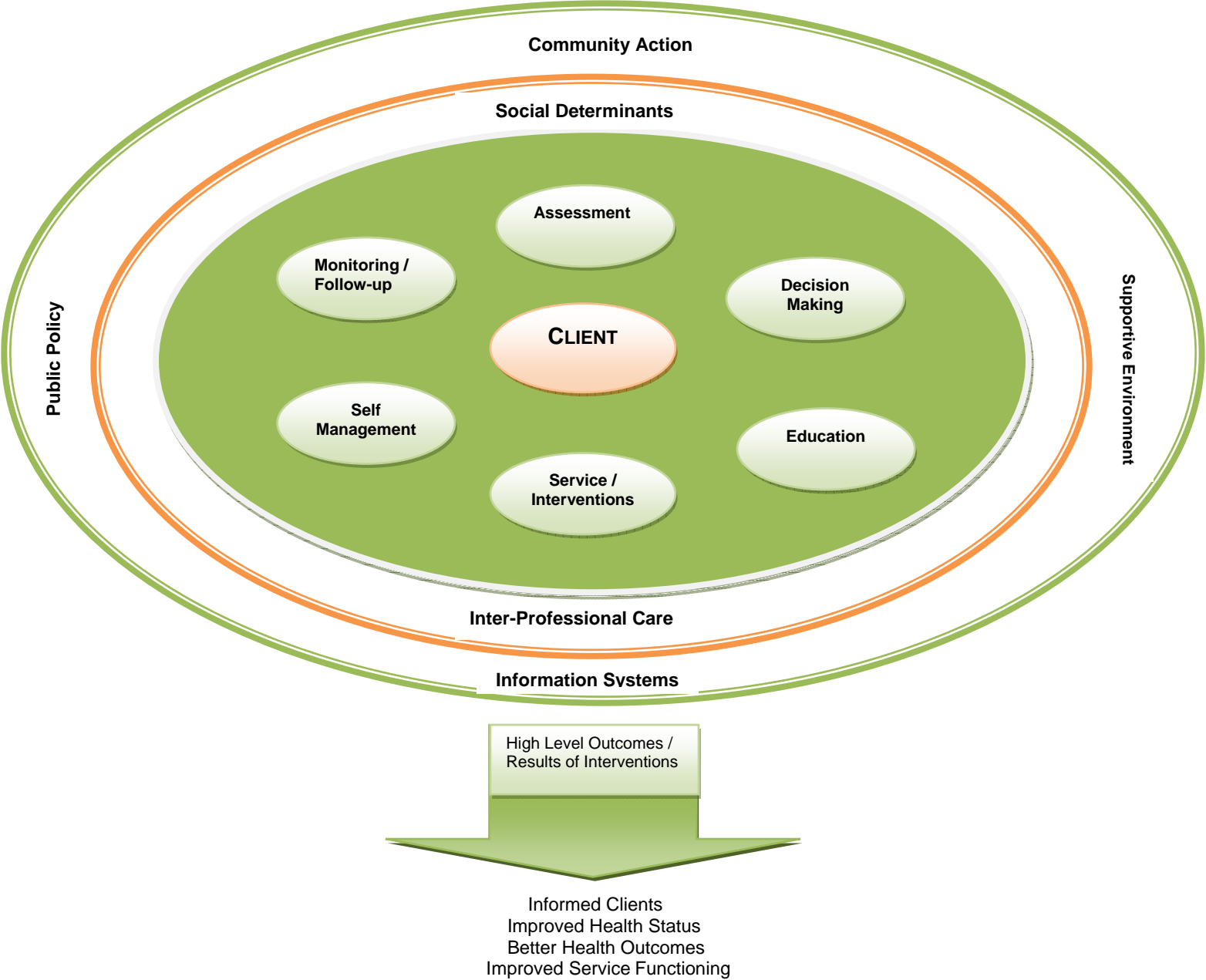
## WHAT IS CHRONIC DISEASE PREVENTION AND MANAGEMENT?

Chronic disease management is a pro-active, population-based approach that addresses chronic diseases early in the disease cycle to prevent disease progression and reduce potential health complications. Multiple strategies are used to improve the health of all clients diagnosed with specific conditions, not only those who visit the provider's office. This approach reduces the subsequent need for acute interventions in the future and allows people to remain healthy for as long as possible.

## GUIDING PRINCIPLES

1. Consistent with the Centre's mandate and values, the approach to Chronic Disease Prevention and Management must be client centered which means that clients are the service "drivers".
2. There are a wide range of chronic diseases, chronic conditions and chronic illnesses present in the Centre's client populations and the community. However, people will be approached in a holistic manner and not as disease or condition entities.
3. There are factors beyond physical illness that pose serious and significant risks of which poverty is a leading risk factor
4. Addressing / including the social determinants of health is critical to positive and healthier outcomes
5. Interventions / supports / education can occur concurrently
6. Harm reduction must be integrated into the CDPM approach where substance abuse is a contributing risk factor
7. Best practices, provider experience and client realities form the care pathways to improved health
8. A "decision tree" will be used to address the most immediate concerns and/or risk elements at various points of involvement

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| <b>Inner Circle Components</b> | <b>Description</b>   |
|--------------------------------|--|
| <b>Client</b>                  | Clients, current and potential; families, support systems, significant persons   |
| <b>Assessment</b>              | Consideration of all factors influencing or impacting on individual's / families' health and well-being. Factors may include physical condition and health status; poverty; housing; employment and access to income; family status; language, culture, race, gender, sexual orientation; literacy; isolation; mental health and mental illness; food access and nutrition and so on. Tools should be designed to capture and reflect basic assessment information using a "whole person" perspective. |
| <b>Decision Making</b>         | A clear process for planning and taking actions by addressing the factors that influence or impact on the client's ability to address their health issues / concerns or to follow through with agreed upon plans. Decisions must be driven by the client and must fully consider underlying factors.   |
| <b>Education</b>               | Information sharing with the client and their family or supports regarding their health issue and/or other factors that may be impacting upon their health and wellness. Information should be based on best practices and/or standards of good practice and presented in a user friendly manner that is observant of cultural, language and literacy sensitivities and relevant to client-identified issues.  |
| <b>Service / Interventions</b> | Specific services provided to, or health and social service interventions directed at a client to assist them in managing their health condition and related concerns.   |
| <b>Self Management</b>         | An individual client's ability to manage their health condition and maintain a relatively stable health status with a reduction in the frequency and/or level of interventions needed or crisis  |
| <b>Monitoring / Follow-up</b>  | Activities and services to maintain client contact and ensure that the client is supported in maintaining a stable health status   |

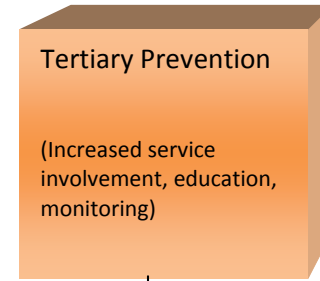
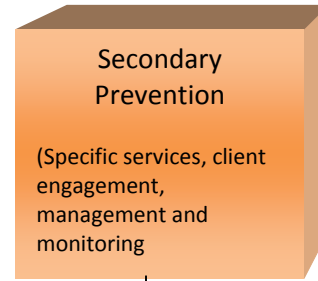
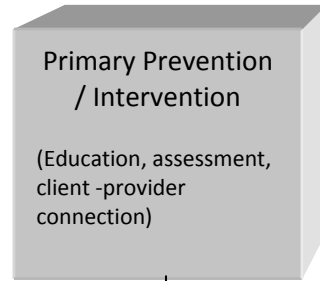
| <b>Mid Circle Components</b>   | <b>Description</b>   |
|--------------------------------|--|
| <b>Social Determinants</b>     | Conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. The social determinants of health may include areas of poverty, housing, gender, racism and discrimination, isolation, age, education, mental health/illness, and so on. |
| <b>Inter-Professional Care</b> | Interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings. (HealthForceOntario)   |

| <b>Outer Circle Components</b> | <b>Description</b>  |
|--------------------------------|---|
| <b>Community Action</b>        | Community action is the involvement by individuals and organizations within the (or a) community working together to identify problems, looking for ways to address them and determining the course of action appropriate to the community. It is based on shared interests, values and resources found within the community. |
| <b>Supportive Environment</b>  | Family members, friends, associates, significant others who individually and/or collectively provide support and connection to the client and each other  |
| <b>Public Policy</b>           | Public policy is a broad statement regarded by the legislature or by the courts as being of fundamental concern to the state and the whole of society. It is the set of policies (laws, plans, actions, behaviours) of a government.  |
| <b>Information Systems</b>     | Information Systems refers to a system of people, data records and activities that process the data and information in an organization, and it includes the organization's manual and automated processes   |

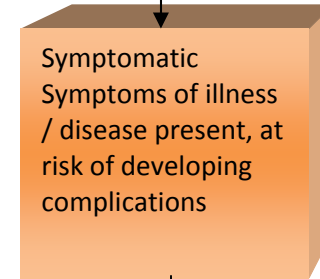
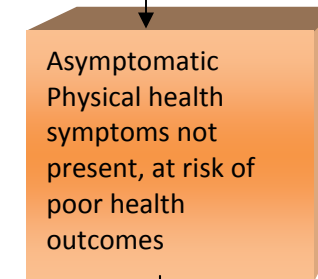
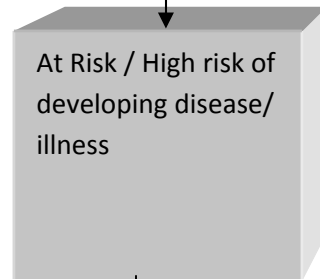
# LEVELS OF PREVENTION

Majority of Hamilton Urban Core Clients

Primary Intervention Strategies



Client Health Status



Effects of interventions

